

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22912

State File No. _____

853

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>11 yrs.</u>		c. CITY OR TOWN <u>St. Joseph</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2705 Lafayette Street Hyatt Park Nursing Home</u>				e. STREET ADDRESS (If rural, give location) <u>1602 South 33rd Street</u> <u>0117</u>			
3. NAME OF DECEASED (Type or Print) <u>MARY</u>		a. (First) <u>I.</u>		b. (Middle) <u>STILES</u>		c. (Last) <u>STILES</u>	
4. DATE OF DEATH <u>Aug. 6, 1956</u>		5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	
8. DATE OF BIRTH <u>July 28, 1873</u>		9. AGE (in years last birthday) <u>83</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Burlington, Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>John Stiles</u>		13b. MOTHER'S MAIDEN NAME <u>Josie Johnson</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Yes Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Miss Katherine Stiles</u> ADDRESS <u>1602 S. 33rd St. St. Joseph, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Month</u> <u>year</u>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <u>Aug 6, 1956</u> , to <u>Aug 6, 1956</u> , that I last saw the deceased alive on <u>Aug 6, 1956</u> , and that death occurred at <u>2:30 P. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Mohammad Ghani M.D.</u>		23b. ADDRESS <u>1306 S. 26 St., St. Joseph, Mo.</u>		23c. DATE SIGNED <u>8-7-56</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug. 8 1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hills</u>		24d. LOCATION (City, town, or county) (State) <u>Near Weston Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Aug 10, 1956</u>		REGISTRAR'S SIGNATURE <u>Ethel M. Allison</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Weston Bowman</u> ADDRESS <u>St. Joseph Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

485

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

William Spalding

Licensed Embalmer No. 4535

P. O. Address 3195 11th St. S. S. P.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.